

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0039586</u></p> <p>Facility Name: <u>NATURE TRAIL HEALTHCARE CENTER</u></p> <p>Address: <u>1001 South 34th Street</u> <u>Mt. Vernon</u> <u>62864</u> Number City Zip Code</p> <p>County: <u>Jefferson</u></p> <p>Telephone Number: <u>(618) 242-5700</u> Fax # <u>(618) 242-5705</u></p> <p>IDPA ID Number: <u>381923423001</u></p> <p>Date of Initial License for Current Owners: <u>06/07/94</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cathy Simeoni</u> Telephone Number: <u>(714) 596-7713, Ext 12</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Linda Holtzscheiter</u></td> </tr> <tr> <td></td> <td>(Title) <u>Reimbursement Manager</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Cathy Simeoni, Manager - Healthcare Consulting</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Kellogg & Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(714) 596-7713, fax 596-7721</u> Fax # ()</td> </tr> </table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Linda Holtzscheiter</u>		(Title) <u>Reimbursement Manager</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>Cathy Simeoni, Manager - Healthcare Consulting</u>		(Firm Name & Address) <u>Kellogg & Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u>		(Telephone) <u>(714) 596-7713, fax 596-7721</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER# 0039586 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,084	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,311	4,537		20,848	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,311	4,537		20,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.98%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/07/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/07/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

NATURE TRAIL HEALTHCARE CENTER

0039586

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,373	8,328	5,575	115,276		115,276		115,276		1
2	Food Purchase		74,175		74,175		74,175	(10,729)	63,446		2
3	Housekeeping	47,979	4,826	184	52,989		52,989		52,989		3
4	Laundry	24,789	5,894		30,683		30,683	(21)	30,662		4
5	Heat and Other Utilities			48,882	48,882		48,882		48,882		5
6	Maintenance	26,842	12,305	12,024	51,171		51,171	211	51,382		6
7	Other (specify):*										7
8	TOTAL General Services	200,983	105,528	66,665	373,176		373,176	(10,539)	362,637		8
	B. Health Care and Programs										
9	Medical Director			5,900	5,900		5,900		5,900		9
10	Nursing and Medical Records	536,242	19,115	5,238	560,595		560,595		560,595		10
10a	Therapy			(5,903)	(5,903)		(5,903)	5,903			10a
11	Activities	26,221	2,219	600	29,040		29,040		29,040		11
12	Social Services	22,092		300	22,392		22,392		22,392		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	584,555	21,334	6,135	612,024		612,024	5,903	617,927		16
	C. General Administration										
17	Administrative	45,910			45,910		45,910		45,910		17
18	Directors Fees										18
19	Professional Services							7,466	7,466		19
20	Dues, Fees, Subscriptions & Promotions			3,968	3,968		3,968	141	4,109		20
21	Clerical & General Office Expenses	48,217	4,767	59,019	112,003		112,003	13,108	125,111		21
22	Employee Benefits & Payroll Taxes			147,349	147,349		147,349		147,349		22
23	Inservice Training & Education			445	445		445		445		23
24	Travel and Seminar			7,179	7,179		7,179	1,259	8,438		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,130	41,130		41,130	803	41,933		26
27	Other (specify):*										27
28	TOTAL General Administration	94,127	4,767	259,090	357,984		357,984	22,777	380,761		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	879,665	131,629	331,890	1,343,184		1,343,184	18,141	1,361,325		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER #0039586 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			27,733	27,733		27,733	96,447	124,180			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			147	147		147	19,871	20,018			32
33	Real Estate Taxes			19,618	19,618		19,618		19,618			33
34	Rent-Facility & Grounds							28,527	28,527			34
35	Rent-Equipment & Vehicles			207	207		207		207			35
36	Other (specify):*											36
37	TOTAL Ownership			47,705	47,705		47,705	144,845	192,550			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,959	7,311	9,270		9,270		9,270			39
40	Barber and Beauty Shops			8,816	8,816		8,816	(8,816)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*							33,016	33,016			43
44	TOTAL Special Cost Centers		1,959	56,753	58,712		58,712	24,200	82,912			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	879,665	133,588	436,348	1,449,601		1,449,601	187,186	1,636,787			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **NATURE TRAIL HEALTHCARE CENTER**# **0039586**Report Period Beginning: **01/01/00**Ending: **12/31/00****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,729)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,592)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,436)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(661)	21		28
29	Other-Attach Schedule	76,754			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 54,336		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	132,850	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 132,850		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 187,186		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
NATURE TRAIL HEALTHCARE CENTER

Page 5A

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
		Reference	
1	Other Sales Taxes	\$ (1,198)	21 1
2	Open House Expense	(626)	21 2
3	Small Balance Adjustment	(15)	21 3
4	Barber and Beauty Revenue	(8,816)	40 4
5	Laundry Revenue	(21)	4 5
6	FAS 121 Depreciation Adjustment **	125,951	30 6
7	Depreciation Reconciliation	(29,504)	30 7
8	Therapy Adjustment	5,963	10a 8
9	Marketing Salary	(14,920)	21 9
10			10
11			11
12			12
13	**The facility re-valued their assets in 1999. We		13
14	have reported the historical costs of the assets		14
15	consistent with the prior years, and have ensured		15
16	that depreciation expense is reported on straight		16
17	line. This adjustment is necessary to reverse the		17
18	re-valuation of historical cost.		18
19			19
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88			88
89			89
90	Total	76,754	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER

0039586

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,729)	0	0	0	0	0	0	0	0	0	0	(10,729)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(21)	0	0	0	0	0	0	0	0	0	0	(21)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	211	0	0	0	0	0	0	0	0	0	211	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,750)	211	0	0	0	0	0	0	0	0	0	(10,539)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	5,903	0	0	0	0	0	0	0	0	0	0	5,903	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	5,903	0	0	0	0	0	0	0	0	0	0	5,903	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,466	0	0	0	0	0	0	0	0	0	7,466	19
20	Fees, Subscriptions & Promotions	0	141	0	0	0	0	0	0	0	0	0	141	20
21	Clerical & General Office Expenses	(28,448)	41,556	0	0	0	0	0	0	0	0	0	13,108	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,259	0	0	0	0	0	0	0	0	0	1,259	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	803	0	0	0	0	0	0	0	0	0	803	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,448)	51,225	0	0	0	0	0	0	0	0	0	22,777	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,295)	51,436	0	0	0	0	0	0	0	0	0	18,141	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER # 0039586 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	5	Utilities	\$	Mariner Post Acute Network	100.00%	\$	\$	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	211	211	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	7,466	7,466	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	141	141	4
5	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	41,556	41,556	5
6	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	1,259	1,259	6
7	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	803	803	7
8	V	32	Interest Expense		Mariner Post Acute Network	100.00%	19,871	19,871	8
9	V	34	Rental & Leasing		Mariner Post Acute Network	100.00%	28,527	28,527	9
10	V	43	Other Expenses		Mariner Post Acute Network	100.00%	33,016	33,016	10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 132,850	\$ * 132,850	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTE # 0039586 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER# 0039586

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Mariner Post Acute NetworkStreet Address One Ravine Dr., Suite 1500City / State / Zip Code Atlanta, GA 30346Phone Number (770) 379-8203Fax Number (770) 399-1971

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			\$	\$		\$	1
2	6	Repairs and Maintenance	Facility Costs						211	2
3	19	Professional Services	Facility Costs						7,466	3
4	20	Fees, Subscriptions, Promotions	Facility Costs						141	4
5	21	Clerical and General Office Exp	Facility Costs						41,556	5
6	24	Travel and Seminar	Facility Costs						1,259	6
7	26	Insurance Premium	Facility Costs						803	7
8	32	Interest Expense	Facility Costs						19,871	8
9	34	Rental & Leasing	Facility Costs						28,527	9
10	43	Other Expenses	Facility Costs						33,016	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 132,850	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Allocation										19,871	7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 19,871	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 19,871	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **NATURE TRAIL HEALTHCARE CENTER**# **0039586**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	19,063	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	19,647	2
3. Under or (over) accrual (line 2 minus line 1).	\$	584	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	19,034	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	19,618	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	16,987	8
	1996	17,975	9
	1997	18,818	10
	1998	19,518	11
	1999	19,647	12

2000 Real Estate Tax Accrual \$19,034

	FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
17,558

B. General Construction Type:

Exterior
BRICK

Frame
STEEL

Number of Stories
1

C.
Does the Operating Entity?

☒ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	225,000	1994	\$ 50,246	1
2					2
3	TOTALS	225,000		\$ 50,246	3

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER

0039586

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1994		\$ 2,213,241	\$ 63,235	35	\$ 63,235		\$ 415,422	4
5			1994		329,317	16,465	20	16,465		107,596	5
6											6
7											7
8											8
	Improvement Type**										
9	INTERIOR BUILDING IMPROVEMENTS			1995	2,325	233	20	233		1,263	9
10	UNIT HEATERS			1996	642	64	20	64		282	10
11	FLOORING - TILE			1996	2,384	119	20	119		497	11
12	HEATERS BASEBOARD -6			1996	502	50	20	50		203	12
13	DRAPES/VALANCES			1996	3,956	396	20	396		1,584	13
14	SMOKE DETECTORS			1996	2,880	288	20	288		1,218	14
15	SIDE RAILS			1996	1,149	57	20	57		194	15
16	PARKING REPAIRS			1997	1,923	96	20	96		315	16
17	WALL COVERING			1997	897	45	20	45		166	17
18	GUTTERS			1997	2,290	115	20	115		364	18
19	BEAUTY SALON			1997	1,040	52	20	52		170	19
20	SEWER TILE			1997	1,575	79	20	79		309	20
21	A/C HEATING UNIT			1997	591	59	20	59		185	21
22	WATER HEATER			1997	388	19	20	19		57	22
23	FLOOR PREPARATION			1997	650	33	20	33		125	23
24	FLOOR COVERING			1997	1,460	73	20	73		278	24
25	FLOOR FINISHING			1997	250	13	20	13		49	25
26	WATER HEATER			1997	388	39	20	39		123	26
27	REBUILDING BATHROOM			1997	3,825	191	20	191		604	27
28	CABINETS/MILLWORK			1998	161	8	20	8		24	28
29	HEATING/VENTILATING			1998	592	30	20	30		34	29
30											30
31	5: HEATERS W/ADAPTERS			1999	2,269	227	10	227		303	31
32	REPAIR WATER LEAK - KITCHEN			2000	1,334	39	20	39		39	32
33	REPAIR WATER LINE - BOOSTER HEATER			2000	986	29	20	29		29	33
34											34
35	FROM PAGE 12.I SUPP					69,276			(69,276)		35
36	TOTAL (lines 4 thru 35)				\$ 2,577,015	\$ 151,330		\$ 82,054	\$ (69,276)	\$ 531,433	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 416,637	\$ 42,005	\$ 42,005	\$		\$ 203,472	37
38	Current Year Purchases	2,616	121	121			121	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 419,253	\$ 42,126	\$ 42,126	\$		\$ 203,593	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,046,514	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 193,456	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 124,180	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (69,276)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 735,026	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	O/H ALLOCATION 1997	\$ 1,583	\$ 79	\$ 191	52
53	O/H ALLOCATION 1997	568	28	63	53
54	O/H ALLOCATION 1996	277	14	50	54
55	O/H ALLOCATION 1996	965	48	148	55
56					56
57	TOTALS	\$ 3,393	\$ 169	\$ 452	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 207 Description: Non-medical equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts			7,157	1,959		9,116	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Audiologist	39				154			154	13
14	TOTAL			\$		\$ 7,311	\$ 1,959		\$ 9,270	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 892	\$	1
2	Cash-Patient Deposits	3,091		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	283,356		3
4	Supply Inventory (priced at)	10,638		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 297,977	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	334,586		13
14	Buildings, at Historical Cost	1,166,789		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	90,427		16
17	Accumulated Depreciation (book methods)	(457,666)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,134,136	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,432,113	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 83,871	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,961		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,386		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,034		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See page 17.1	113,335		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 301,587	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See page 17.1	3,269,776		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,269,776	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,571,363	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,139,250)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,432,113	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,385,902)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,385,902)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	246,652	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 246,652	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,139,250)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,098,262	1
2	Discounts and Allowances for all Levels	(415,307)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,682,955	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,729	13
14	Non-Patient Meals	2,592	14
15	Telephone, Television and Radio	(21)	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,300	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,696,255	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	373,176	31
32	Health Care	612,025	32
33	General Administration	357,984	33
	B. Capital Expense		
34	Ownership	47,706	34
	C. Ancillary Expense		
35	Special Cost Centers	18,086	35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,449,603	40
41	Income before Income Taxes (line 30 minus line 40)**	246,652	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 246,652	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **NATURE TRAIL HEALTHCARE CENTER**# **0039586**Report Period Beginning: **01/01/00**Ending: **12/31/00**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,087	2,206	\$ 37,767	\$ 17.12	1
2	Assistant Director of Nursing	946	1,000	15,121	15.12	2
3	Registered Nurses	6,456	6,823	97,532	14.29	3
4	Licensed Practical Nurses	10,071	10,644	121,068	11.37	4
5	Nurse Aides & Orderlies	30,206	31,925	258,628	8.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,011	2,125	18,105	8.52	9
10	Activity Assistants	1,254	1,325	7,983	6.02	10
11	Social Service Workers	2,035	2,151	22,285	10.36	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,122	25,834	12.17	13
14	Head Cook	5,919	6,256	49,705	7.95	14
15	Cook Helpers/Assistants	4,084	4,317	26,239	6.08	15
16	Dishwashers					16
17	Maintenance Workers	1,923	2,033	26,530	13.05	17
18	Housekeepers	6,490	6,859	48,891	7.13	18
19	Laundry	3,728	3,940	25,070	6.36	19
20	Administrator	2,024	2,139	47,040	21.99	20
21	Assistant Administrator					21
22	Other Administrative	1,934	2,044	21,850	10.69	22
23	Office Manager					23
24	Clerical	480	507	8,635	17.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	672	710	6,462	9.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,042	1,101	14,920	13.55	33
34	TOTAL (lines 1 - 33)	85,370	90,227	\$ 879,665 *	\$ 9.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	71	\$ 2,680	1-3	35
36	Medical Director	48	5,900	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	600	11-3	44
45	Social Service Consultant	24	600	12-3	45
46	Other(specify) <u>Administrative</u>	8	370	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	175	\$ 10,150		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Johnsin, Steven	Administrator	0	\$ 45,910	Workers' Compensation Insurance		\$ 19,814	IDPH License Fee	\$ 400	
				Unemployment Compensation Insurance		12,419	Advertising: Employee Recruitment		
				FICA Taxes		64,769	Health Care Worker Background Check		
				Employee Health Insurance		48,758	(Indicate # of checks performed _____)		
				Employee Meals			Dues	3,568	
				Illinois Municipal Retirement Fund (IMRF)*		705			
				Other Employee Benefits		884	Home Office Allocation	141	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									
\$ 45,910									
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	7,179	
							Seminar Expense		
							Home Office Allocation	1,259	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$				TOTAL	\$ 8,438	

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number NATURE TRAIL HEALTHCARE CENTER

STATE OF ILLINOIS

0039586

Report Period Beginning:

01/01/00

Ending:

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12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTH CARE ASSOC \$3504
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,626
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.